IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 9, 2007

Renae Edwards, Administrator
Indianhead Estates
590 W Indianhead Rd
Weiser, ID 83672

Dear Ms. Edwards:

On February 5, 2007, a complaint investigation survey was conducted at Indianhead Estates. The survey was conducted by Maureen McCann, RN and Patrick Hendrickson, RN. This report outlines the findings of our investigation.

Complaint # ID00002437

Allegation #1: The facility did not assist an identified resident with her ADL's including hair washing and trimming of her toenails.

Findings: Based on interview and review of a closed record it was determined the facility did assist the identified resident with her ADL's, hair washing and trimming her toenails.

Review of the identified resident's "Shower Log" on February 5, 2007 documented the resident had been assisted with 5 showers during July 06, 3 showers during August 06, 4 showers during September 06, 5 showers during October 06, 4 showers during November 06 and 3 showers befor being discharged in December 06.

Review of the identified resident's "Nail log" on February 5, 2007 documented the resident had been assisted with the trimming of her toenails on February 1, 2006, April 12, 2006, May 28, 2006, June 30, 2006, July 13, 2006, September 9, 2006, October 3, 2006, November 3, 2006, November 20, 2006, and December 22, 2006.

On February 5, 2007 at 1:00 p.m., a care giver that had worked with the resident stated the resident often refused showers but when reaproached at another time she would eventually take one.

On February 5, 2007 at 1:30 p.m. the administrator stated the resident was assisted with a shower a week.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation conducted on February 5, 2007.

Allegation #2: The identified resident had skin breakdown in the folds of her abdomen and peri-area to include abscess.

Findings: Based on interview and the review of a closed record it was determined the identified resident did have skin breakdown in the folds of her abdomen and peri-area that include an abscess.

Review of the identified resident's "Progress Notes" on February 5, 2007 documented the following;

August 25, 2006 "rash under her folds"

August 27, 2006 "refused to let staff apply cream"

August 31, 2006 "yeast infection under folds started antibiotics"

September 11, 2006 "biopsy of wound taken at physicians office today"

October 1, 2006 "skin flaking and pealing, resident allergic to antibiotics"

Review of the identified resident's "Nursing Assessment" on February 5, 2007 documented the facility nurse assessed the residents skin and wound on September 27, 2006, October 11, 2006 and October 25, 2006.

Review of the identified resident's "Physician Progress Notes" on February 5, 2007 documented the resident was seen by her physician regarding her skin integrity on Septermber 11, 2006.

On February 5, 2007 at 1:30 p.m. the administrator stated the identified resident did have skin issues that were resolving slowly. She further stated the resident's physician, facility nurse, staff and herself were involved in the treatment and monitoring of the residents skin condition.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by involving the identified resident's physician, facility nurse, staff and the administrator in the treatment and monitoring of the residents skin condition.

Allegation #3: The identified resident's closet door was broken.

Findings: Based on observation and interview, it was determined that the resident's closet door was broken

On February 5, 2007 at 11:30 a.m., the facility's Administrator stated that the identified resident's closet door had come off it's hinges several times during the residents stay at the facility. She further stated that maintanance staff had fixed the closet door each time it had fallen off it's hinges.

On February 5, 2007 at 12:30 p.m., the identified resident's closet door was viewed to be operational and on it's hinges.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by fixing the closet door each time it came off it's hinges.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

PATRICK HENDRICKSON, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program